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Issue Date: 11 July 2007

Case No: 2006-LHC-01122

OWCP No: 05-118187

In the Matter of:

L.T.,

Claimant,

v.

NEWPORT NEWS SHIPBUILDING
AND DRY DOCK COMPANY,

Employer.

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended (Act), 33 U.S. Code, Title 33, § 901 et seq., and is governed by the implementing Regulations found in the Code of Federal Regulations, Title 29, Part 18, and Title 20, Chapter VI, Subchapter A.

A formal hearing scheduled to be held in Newport News, Virginia, on March 20, 2007, was cancelled upon a joint request for a decision based on the evidence of record. Administrative Law Judge Exhibits 1 through 6, Claimant's Exhibits 1 through 4, and Employer's Exhibits 1 through 13 were marked and considered. The post-hearing written briefs filed by the respective counsel for the Claimant[1] and the Employer were also considered.

The findings of fact and conclusions which follow are based upon a complete review of the entire record, in light of argument of the parties, as well as applicable statutory provisions, regulations and pertinent precedent.

[1] After August 1, 2006, the Department of Labor policy requires the use of initials for claimants' name in the headings and use of a descriptive title in the decision. Accordingly, "Claimant" is used in this decision vice the proper name of the individual who is the subject of this decision.

STIPULATIONS

The parties did not stipulated to any specific findings of fact.

ISSUES

The issues remaining to be resolved[2] are:

1. Whether Claimant suffered a right knee injury as a proximate result of a covered work-related injury to the left knee on February 12, 2004; and,

2. Whether Claimant is entitled to medical treatment under the Act for the right knee injury.

PARTY CONTENTIONS

***Claimant's Contentions*:**

Claimant's counsel asserts that the Claimant suffered a work-related left knee injury on February 12, 2004 while climbing a ladder at work and that the Employer accepted the left knee injury as compensable under the Act. Subsequently the Claimant underwent left knee surgery on March 3, 2004. In 2005, the Claimant reported right knee pain and sought medical treatment. Thomas M. Stiles, M.D. treated the Claimant from May 12, 2005, through November 17, 2005, and diagnosed torn meniscus and areas of chondromalacia in the right knee. Counsel argues that Dr. Stiles' opinion that the left knee injury, left knee surgery and period of non-weight bearing left leg contributed to the problems in the right knee coupled with the presumption of Section 920(a) of the Act entitles the Claimant for medical treatment of the right knee. Claimant's counsel also argues that the left knee injury of February 12, 2004, aggravated a pre-existing condition in the right knee such that the Employer is liable for the medical expenses incurred in treating the right knee.

***Employer's Contentions*:**

Employer's counsel argues that the weight of the evidence demonstrates that the left knee injury did not cause, contribute to, or materially worsen the Claimant's pre-existing right knee problems and that the right knee problems are the result of direct right knee injuries and longstanding progressive degenerative changes in the right knee joint.

Employer's counsel submits that the evidence contradicts the opinion of Dr. Stiles of a causal connection of the left knee injury to the right knee problems and that the treating physician's opinion is impeached by his progress notes and lack of historical, clinical and evidentiary foundation. Employer's counsel lists prior right knee injuries, two right knee surgeries and pre-existing right knee pathology requiring the need for handicap parking prior to the February 12,

[2] Based upon the LS-18 forwarded by the Director in ALJX 2 and presented in the post-hearing briefs of counsel.

2004, left knee injury, as the cause of the need for right knee medical care. He also submits the medical opinions of Dr. Blasdell and Dr. Apostoles should be given greater weight based on their respective analysis of the longstanding medical history of severe pre-existing arthritic changes in the right knee and the absence of increased pathological changes or changed clinical presentation of the right knee after the left knee injury of February 12, 2004. Their respective opinions are that the February 12, 2004 left knee injury played no role in the clinical presentation of the right knee and the current right knee impairment is unrelated to the February 12, 2004, work-related injury.

Employer's counsel argues that the evidence demonstrates that the February 12, 2004, left knee work-related injury played no part in the right knee impairment and that the claim for right knee medical and benefits under the Act should be denied.

SUMMARY OF RELEVANT EVIDENCE

Medical Record Entries by Thomas M. Stiles, M.D. (CX 1)

CX 1 contains five medical records entries. On May 12, 2005, the Claimant was seen for follow-up on his right knee. The Claimant complained of pain and swelling in the right knee and being out of prescribed Motrin for some time. He reported working a job without climbing, squatting, or kneeling so that his knee was doing much better than when he was working in the shipyard. On examination, Dr. Stiles reported considerable crepitation with flexion extension and mild effusion without heat, redness or instability. Dr. Stiles prescribed Motrin and a note for an active exercise program at the YMCA for rehab of the right knee.

On August 10, 2005, the Claimant was seen in follow-up with complaints of increased knee pain, right greater than left. He had not participated in an exercise program at the YMCA. On examination, Dr. Stiles reported some pain with flexion extension on both knees with the right knee worse. There was considerable crepitation with motion on the right knee, particularly along the lateral joint line. Dr. Stiles order bilateral knee x-rays and active exercise program at the YMCA.

On September 15, 2005, the Claimant returned to Dr. Stiles with the knee x-rays. Dr. Stiles reported the x-rays demonstrated rather marked traumatic arthritis in both sides with marked lipping on the tibia and femoral condyles. There was considerable joint space narrowing medially with essentially no space left in the medial compartment on the left and approximately one centimeter on the right. Dr. Stiles changed the Motrin prescription to Mobic and advised the Claimant of his treatment options of living with his knees as they were, receiving Synvisc injections to the knees or having total knee replacement surgery.

On November 2, 2005, the Claimant was seen for acute swelling in the right knee. The Claimant reported a twisting injury and fall the day before with pain and swelling since that time. On examination, Dr. Stiles reported definite effusion of the right knee with no reproducible

instability in either the anterior drawer or pivot shift. He removed approximately 50 cc of blood and fluid from the knee. The Claimant was sent for an MRI of the knee.

On November 17, 2005, the Claimant was seen in follow-up of the right knee. He reported that the right knee was doing much better with subsided swelling and less pain. Dr. Stiles reported the MRI showed a tear of the medial and lateral meniscus and that advised to pursue exercise and activity program at the YMCA as well as daily anti-inflammatory medicines. The Claimant was directed to return in four weeks.

Medical Report of J. H. DeMeo, M.D. (CX 2)

By form report dated August 15, 2005, J.H. DeMeo, M.D., reported his medical radiology interpretation of the right and left knees that was ordered by Dr. Stiles. Dr. DeMeo reported marked degenerative changes in the knees bilaterally with medial compartment narrowing and bilateral joint effusions.

Medical Report of D.S. Kothmann, M.D. (CX 3)

On November 7, 2005, D.S. Kothmann, M.D. reported on the MRI of the right knee. Dr. Kothmann reported finding the anterior cruciate ligament as thin/attenuated most consistent with previous insult and incomplete tear. There was moderate to advanced degenerative change in the medial joint compartment with thinning of articular cartilage and formation of prominent osteophytes with joint space narrowing. Moderate degenerative change was seen in the lateral joint compartment. There was an abnormal signal consistent with tear in the body of the medial meniscus and anterior horn of the lateral meniscus. There was moderate thinning of the patellar articular cartilage and patellofemoral degenerative change with osteophytes. Moderate joint effusion was present. Dr. Kothmann's impression was moderate to advanced degenerative change in the medial joint compartment, moderate degenerative joint disease laterally, free edge tear of the body of the meniscus and anterior horn of the lateral meniscus, moderate chondromalacia patella with patellofemoral degenerative change, focal marrow edema in the inferior pole of the patella, moderate sized joint effusion, and chronic thinning/attenuation of the anterior cruciate ligament.

Medical Opinion Letter of Thomas M. Stiles, M.D. (CX 4)

By letter dated September 7, 2006, Thomas M. Stiles, M.D., reported that he had treated the Claimant from February 1996 following a right knee injury which required arthroscopic surgery which led to improvement in the right knee and return to essentially normal duties. He reported the Claimant injured his left knee in February 2004 and had subsequent surgery on the left knee and recovery requiring him to be on crutches, non-weight bearing on the left side for a considerable period of time. Dr. Stiles reported that when seen again in 2005, the Claimant complained of right knee pain and had a torn meniscus and areas of chondromalacia. Dr. Stiles opined that the Claimant's "injury of 2004,… his subsequent [left knee] surgery, and the time

that was spent when he was unable to put weight on the left side, has contributed to the problem in his right knee."

District Director Compensation Order of December 30, 2004 (EX 1)

On December 30, 2004, the District Director for the Fifth Compensation District, U.S. Department of Labor, enter a "Compensation Order Award of Compensation" involving the Parties. The Order included findings that the Claimant had sustained injuries to his left knee while working as a shipbuilder for the self-insured Employer on February 12, 2004; the average weekly wage was $877.82; the Claimant was entitled to temporary total disability compensation from February 19, 2004 to August 16, 2004, inclusive, in the amount of $15,048.25; the Claimant was entitled to permanent partial disability for 20% loss of use of the left lower extremity in the amount of $33,708.10; and the Employer had furnished medical treatment as required by the Act. The Employer was ordered to pay the awarded disability compensation and to continue to provide medical services to the Claimant in accordance with Section 7(a) of the Act.

District Director Letter of February 2, 2006 (EX 2)

By letter dated February 2, 2006, the District Director notified Claimant's counsel that he had reviewed the medical evidence submitted by counsel regarding medical treatment for the Claimant's right knee and would not be conducting an informal conference on the matter. Claimant's counsel was advised that she could request a hearing by submitting an LS-18 form.

LS-208 Notice of Final Payment or Suspension of Compensation Payments (EX 3)

Employer Exhibit 3 indicates that the Claimant sustained a work-related injury to the right lower extremity on January 8, 1996. The average weekly wage rate at the time of injury was $689.80. The Claimant was paid temporary total disability compensation from March 5, 1996, through March 18, 1996 (totaling $919.74), from May 8, 1996, through June 26, 1996 (totaling $3,284.79), and from July 24, 1996, through May 26, 1997 (totaling $20,168.59). He was paid permanent partial disability compensation based on a 20% permanent disability rating to the right lower extremity in the total amount of $12,916.37.

Report of Medical Examination by S.C. Blasdell, M.D. (EX 4)

On October 31, 2006, the Claimant was examined by S.C. Blasdell, M.D. Dr. Blasdell summarized his review of the Claimant's medical records from Dr. Stiles for the period February 12, 2004, through November 17, 2005, in a manner consistent with the medical record summaries herein for exhibits CX 1, EX 8 and EX 9.

Dr. Blasdell reported the Claimant's complaints as painful popping and give-way sensations in both knees, right knee pain greater than left. Dr. Blasdell reported the Claimant with a history of right knee arthroscopy with synovectomy, removal of loose bodies, and lateral femoral condyle debridement on July 9, 1990. He underwent a repeat right knee arthroscopy with removal of loose bodies, femoral condyle chondroplasty and synovectomy on May 8, 1996. He has a history of heart problems requiring cardiac catherization as well as hypertension. He took Motrin and medication for the heart and hypertension.

On examination, Dr. Blasdell reported the Claimant as 5'7" tall at 230 pounds. There was bilateral medial and lateral joint tenderness of the knees. Knee range of motion was 100 minus 10 right and 120 minus 0 left. Lachman's sign was negative bilaterally. There was +1 effusion of the right knee with no effusion reported on the left. X-rays of the knees revealed bilateral osteoarthritic changes with osteophytes, right greater than left, varus deformities, and osteopenia. Dr. Blasdell diagnosed severe osteoarthritis bilateral knees. His opinion was that the Claimant did not sustain any right knee injury as a result of the February 12, 2004 work episode involving the left knee. He opined that the right knee arthritis and current right knee impairment is unrelated to the February 12, 2004 work episode.

Report of Medical Record Review by P.S. Apostoles, M.D. (EX 5)

By letter dated September 15, 2006, Dr. Apostoles, M.D., reported that he had the opportunity to review the Claimant's medical records, not further identified. He reported that the Claimant had "pre-existing pathology in the right knee which had already resulted in two prior surgeries. The records are devoid of any reference to increased symptoms in the right knee following the left knee injury [of February 12, 2004] until September 15, 2004 when [the Claimant] complained of chronic pain in both legs. … Although the pathology described in the right knee (a torn medial meniscus and lateral meniscus) could be consistent with the acute [twisting] injury [the Claimant] reported on November 1, 2005, it is more probable than not the result of the previous right knee surgeries and the natural progression of the pre-existing condition in the right knee." Dr. Apostoles opined that "the left knee injury of February 12, 2004, did not lead to the surgery, pathology or disability attributable to the opposite knee. … there is sufficient medical evidence to explain the right knee disability independent of the left knee injury."

Hospital Medical Records (EX 6)

On April 26, 1990, the Claimant underwent an MRI of his right knee upon complaints of right knee pain and suspected chondromalacia. The study revealed a large suprapatellar effusion and extensive fat anterior to the knee joint, adjacent to the medial facet of the patella, and between the suprapatellar bursa and femur. The remainder of the findings were within normal limits.

On July 9, 1990, the Claimant was admitted to Mary Immaculate Hospital for day arthroscopic surgery involving the right knee. Dr. Stiles performed the arthroscopic surgery and excised "a rather large plica" from the suprapatellar pouch, removed loose bodies and debrided the lateral

compartment, medial femoral condyle and notch. The material removed did not show inflammation.

On May 8, 1996, Dr. Stiles performed arthroscopic day surgery to the right knee at Mary Immaculate Hospital. Loose bodies were suctioned out in several areas, the condylar surfaces, femur and lateral tibial plateau were debrided. No tears were seen. Post-operative diagnosis included chondromalacia of the medial and lateral femoral condyles and chondromalacia of the notch.

On June 7, 1996, Dr. Stiles signed an "Attending Physician's Statement of Disability" stating that he expected the Claimant to be totally disabled from May 8, 1996 through July 30, 1996.

On July 11, 1996, Dr. Stiles opined that the Claimant had an "old internal derangement - right knee" and that he was not totally disabled from his regular occupation or any other kind of employment. On July 18 2996, Dr. Stiles reported he had released the Claimant to return to work with light duty work restrictions, effective June 27, 1996, and that he had been totally disabled from work from May 8, 1996 (the day of arthroscopic right knee surgery) through June 27, 1996.

On November 7, 2005, the Claimant underwent an MRI of the right knee as reported in CX 1, above.

Report of Occupational Injury (Illness) dated February 17, 2004 (EX 7)

On February 18, 2004, the Claimant signed a typed report form stating that on February 12, 2004, he "was going up a ladder and felt a pop in my left knee." The report indicates the injury occurred in the "Sub Shop" at 1:30 PM, February 12, 2004, and that first treatment of the injury was at 9:45 AM, February 17, 2004. The Claimant was referred to Dr. Stiles, per Claimant's request.

On February 18, 2004, J.C. Daimler, M.D., reported interpretation of a left knee x-ray taken on February 17, 2004, as indicating degenerative change in all three compartments with marginal osteophyte formation as well as joint space loss in the medical compartment.

On September 16, 2004, J. Baylous, M.D., reported a radiological interpretation of the left knee as indicating severe medial joint space degenerative changes with moderate patellofemoral degenerative changes and no fracture.

Progress notes from the Employer's medical clinic indicate the Claimant was seen February 17, 2004, with a complaint of hurting the left knee February 12, 2004, and noticed swelling on Saturday. Examination revealed mild joint effusion without joint laxity. The notes reflect that the Claimant was off work duties through June 7, 2004, per Dr. Stiles, and that work restrictions from Dr. Stiles had been received by August 2, 2004. An August 16, 2004, entry noted the requirement to wear a knee brace during full duty status.

Medical Record Entries by Thomas M. Stiles, M.D. (EX 8)

EX 8 contains nine medical record entries made by Dr. Stiles for 2004 and 2005. Five of those entries are as summarized in CX1, above.

On February 18, 2004, the Claimant was seen for acute left knee pain and complaints that the pain had become markedly worse the past three to four days and swelling had increased. He reported the pain had kept him from sleeping. He denied acute swelling or redness in any other joint. On examination, the Claimant ambulated with a definite limp, kept his knee in approximately 20 degrees of flexion, had rather severe marked swelling and some increased warmth of the left knee. He had pain with manipulation in any direction and the knee was locked in about 30 degrees flexion. His anterior drawer and medial lateral stressing was negative for tears. X-rays showed moderate degenerative changes with lipping along the medial joint line and raised a question of a loose body. Dr. Stiles blocked and aspirated the knee, removing over 70 ccs of yellow fluid. The Claimant was taken out of work, had his left knee injected with Depomedrol and ordered for an MRI. Dr. Stiles suspected a meniscal tear as a result of the February 12, 2004 injury.

When seen in follow-up on February 23, 2004, the left knee was quite symptomatic with marked difficulty ambulating and pain at rest. The MRI revealed a tear of the medial meniscus and he was scheduled for surgery. Examination indicated complete lack of left knee extension and painful medial McMurray's testing with effusion. He remained out of work.

When seen on July 19, 2004, the Claimant was doing relatively well, with some difficulty going up and down stairs and changing into and out of a seated position. The range of motion was good with very mild effusion. The left side quadriceps were weaker than the right side. The Claimant was released for a light duty job with work restrictions.

Work restrictions were removed on August 16, 2004.

On September 23, 2004, Dr. Stiles reported the Claimant was back at work with no restrictions and was able to handle that. Examination revealed considerable crepitation with flexion extension of the left knee. X-rays indicated a 1 mm of cartilaginous space in the medial knee joint, 2 mm of space in the medial patella joint. The left quadriceps were 2.0 sonometers less than the right quadriceps. Dr. Stiles opined that the Claimant had a 33% permanent impairment of his left lower extremity based predominately on the loss of cartilaginous space in the knee joint. Dr. Stiles reported the quadriceps atrophy and excision of the meniscus were not considered in the impairment rating.

Medical Record Entries by Thomas M. Stiles, M.D. (EX 9)

EX 9 contain numerous medical record entries from May 3, 1990. Those entries duplicative of entries summarized above are not again addressed.

On May 3, 1990, the Claimant was seen by Dr. Stiles for acute swelling of the right knee for injury incurred while working on his knees three month previously. The Claimant reported some anterior pain and mild swelling. On examination there was mild effusion in the knee with good range of motion and no instability. X-rays showed his patella to be riding high. He was given a patella brace, directed to continue his medications at night and continue work limitations.

On May 30,1990, the Claimant reported he had discontinued use of the patella brace. By the June 27, 1990, visit, the Claimant reported pain in the knee, that therapy was helping, but that he was walking to and from therapy sessions because the bus took too long to return him to work. Dr. Stiles opined that he would plan to scope the knee and do a patella shave.

On July 16, 1990, Dr. Stiles reported the Claimant had arthroscopic surgery with debridement of the femoral condyle. Now he had marked swelling. 50 cc of blood was aspirated from the knee. By August 6, 1990, the knee was improving and swelling was down. There was good range of motion. The Claimant was to begin range of motion and exercise program at home. The September 5, 1990 visit revealed moderate swelling and a need to continue active range of motion program at home.

On October 3, 1990, Dr. Stiles reported the knee doing better and that the Clamant was to continue the active use program and begin back to work program with no climbing, kneeling or squatting. The November 13, 1990, visit continued the October exercise program and work restrictions.

When seen on January 24, 1991, the Claimant reported some pain on climbing and inability to run on the knee. The range of motion was good without instability or swelling. Dr. Stiles opined that the Claimant had a 15% permanent disability of the right leg and should be on permanent work restriction of no climbing.

On July 30, 1991, Dr. Stiles reported that the Claimant complained of low back pain for some time and had received therapy from the shipyard for the back. X-rays indicated a Schmorl's type node at the 5^{th} lumbar with narrowing. An MRI was directed. Dr. Stiles reported that he had nothing in his records to connect the Claimant's low back pain to his knee pain. By an August 29, 1991, entry Dr. Stiles reported that he had no authorization to treat the low back pain and that the knee was about the same.

On February 19, 1996, the Claimant was seen for acute pain in the right knee for several weeks. Examination indicated moderate effusion and acute pain with manipulation, tenderness along the medial joint line, and moderate crepitation with flexion extension. X-rays of the knees showed some degenerative changes particularly along the medial joint line. An MRI was ordered and the Claimant directed to take anti-inflammatory medication, stay off his knee for a week, and then back to work with restrictions.

The March 4, 1996, follow-up revealed the Claimant was out of work for one week with improvement in the knee following. The Claimant reported he had returned to work and the right knee problem had returned. On examination there was mild effusion. The Claimant was taken off-work for two weeks then return to work with restrictions.

On April 17, 1996, the Claimant reported the knee was worse and he would like to proceed with surgery. An MRI indicated chondromalacia throughout the knee with multiple loose bodies.

When seen on May 15, 1996, the Claimant was post-arthroscopic shaved chondroplasty and loose body removal of the right knee. Examination revealed moderate effusion, moderate pain, and weak quadriceps. He was to remain non-weight bearing. Report of the May 30, 1996, follow-up was similar with moderate swelling reported and direction to pursue a very active therapy program and begin weight bearing as tolerated. The Claimant remained out of work.

On June 26, 1996, the swelling was down, range of motion was fairly good, and the quadriceps were still quite weak. The Claimant was advised to continue an active quadriceps strengthening program and return to work in a very light duty situation.

The July 29, 1996, follow-up examination mistakenly listed the impaired knee as left vs. right. The Claimant was clinically improving but had trouble standing on one leg and displayed a limp on ambulation. He was to continue therapy and work restrictions. An August 28, 1996, record entry indicates that the Claimant had been discharged form therapy and that the Claimant was directed to continue a home exercise program

At the September 25, 1996 follow-up on the right knee, the Claimant reported moderately symptomatic when getting up and down from sitting and with attempts to run or walk fast. Examination revealed weak quadriceps on the right and moderate crepitation with flexion extension without effusion. He had good range of motion. Work restrictions included not crawling, working in tight places, squatting, kneeling or stooping. He was advised to be in an active exercise program. There was no essential change in the November 6, 1996 examination.

On December 18, 1996, the Claimant was symptomatic in the right knee and unable to squat, kneel or run. He was advised to continue an active exercise program. Dr. T.M. Stiles opined that the Claimant "will have a permanent disability in the right knee [but] he needs to improve considerably before he reaches MMI."

On January 30, 1997, the Claimant reported catching and popping in the right knee. Examination revealed good range of motion without marked swelling, mild crepitation, and tenderness anteriorly. He was released to work with new work restrictions. On March 27, 1997, his work restrictions were rewritten to include no squatting, kneeling or crawling. The work restrictions were "lighted" by Dr. Stiles on May 22, 1997.

On August 21, 1997, x-rays indicated narrowing in the right knee medial compartment and patella femoral compartment. He had very limited range of motion and mild crepitation with flexion extension.

On September 15, 1997, Dr. Stiles reported that the Claimant "at his last arthroscopic surgery the Claimant had rather severe post-traumatic arthritic findings with loss of chondral cartilage in both the medial and lateral compartments and patella femoral compartment. His most recent x-rays including a standing AP, showed narrowing of the medial compartment as well as patellofemoral compartment. In my opinion, he has a 20% permanent disability of his right knee

as a result of these problems. I do not think this will improve in the future. It is also my opinion this is going to get worse in the future and he may require further surgery."

A February 24, 1999, entry indicated that the Claimant had pain in his left shoulder from "just back before Christmas, he was crawling through a tight hole to do some welding and when he got into the hole he noted that his shoulder was bothering him somewhat." The entry indicates that this event occurred while the Claimant was performing his work as a welder for Employer. Left shoulder medical entries are present for April 27, 2000, and April 3, 2001.

On March 26, 2003, Dr. Stiles saw the Clamant for complaints of right knee pain while back to work at full duty. On examination, the Claimant had good range of motion with obvious arthritic lipping along the medial and lateral condyle. Loose bodies may have been present. There was no increased heat, redness, real effusion or instability. He was given a handicap sticker and directed to return to his YMCA exercise program.

The results of the February 18, 2004, left knee MRI and Dr. Stiles medical record entries for February 18, 2004, February 23, 2004, July 19, 2004, August 16, 2004, and September 23, 2004, are as summarized in EX 8, above.

Additional left knee medical record entries for 2004 include those of the March 9, 2004, post-operative examination which indicated that the left knee was moderately swollen and tender in the posterior medial incision. The left knee was aspirated and he was advised to start a gentle exercise program. On March 16, 2004, the left knee had a "fair sized effusion" without real pain complaints. The Claimant was prescribed Motrin. Mild swelling was present on March 23, 2004, with very weak left quadriceps and no redness or heat. He was placed on minimal weight bearing, Motrin and active exercise program. On April 6, 2004, the Claimant was able to place some weight on the left knee while using crutches. There was mild effusion, weak quads and pain at 60-70 degrees flexion. On April 20, 2004, the left knee surgical wounds were clean and smooth. Mild effusion was present. The Claimant was referred to physical therapy.

The May 18, 2004, entry reports "follow up on his right knee" but the therapy report reviewed and therapy attendance of three times per week indicates that this was really an evaluation of the left knee. The report was moderately symptomatic with considerable quadriceps weakness. Vicodin was prescribed for pain.

The June 7, 2004, entry for left knee follow up, post-operative, continued the Claimant as out-of-work, directed continuation of therapy three days per week, and reported good range of motion, minimal swelling, marked quadriceps atrophy, and without enough muscle to return to work at this time. On June 28, 2004, the Claimant had difficulty ambulating with the left knee beyond 100 to 150 yards. He was placed in an active water therapy program.

On September 15, 2004, the Claimant reported being back to work on cement with pain in both knees, left greater than right, and difficulty when first up from a seated position and taking the first three or four steps. On examination, he had good range of motion, minimal effusion, some crepitation in McMurray's and no marked instability. He was sent for an x-ray so he could be

evaluated for a permanent disability rating. As noted in EX 8, above, Dr. Stiles assigned a 33% permanent impairment rating to the left knee on September 23, 2004.

Dr. Stiles' medical record entries for May 12, 2005, August 10, 2005, September 15, 2005, November 7, 2005 and November 17, 2005, are as summarized in CX 1, above.

Left Knee Operative Report of March 3, 2003 (EX 10)

EX 10 contains the report of left knee arthroscopic surgery performed on March 3, 2004. The arthroscopy revealed generalized synovitis with multiple loose bodies, complex tear of the medial meniscus with a large portion of the meniscus missing, chondromalcia of the medial femoral condyle and medial tibial plateau, a large exostosis along the femoral condyle, and a Baker's cyst. The medial compartment was debrided. A chondroplasty was performed of the tibial plateau, the medial and lateral femoral condyle, the patella and the femoral trochlea. The medial meniscus was resected. The exostosis was debrided.

D.S. Kothmann, M.D., Report of Right Knee MRI of November 7, 2005 (EX 11)

EX 11 is the same information as set forth in CX 2 and CX 3, above.

Curriculum Vitae of P.S. Apostoles, M.D. (EX 12)

P.S. Apostoles, M.D., graduated from the University of Virginia Medical School in 1989. He is board eligible in orthopedics and the current medical director at the Employer's medical facilities. He was an orthopedic surgeon for five years (1995 – 2000) and a staff physician with NowCare since 2000 with responsibilities in orthopedic injury evaluations, acute care, and physical examinations. He is published in six professional publications from 1981 to 1994, with the last two pertaining to the knee and orthopedic trauma.

Curriculum Vitae of S.C. Blasdell, M.D. (EX 13)

S.C. Blasdell, M.D., received his medical degree from the University of Rochester in 1981. He completed his residency in orthopedics and became chief resident and instructor at Strong Memorial Hospital in Rochester, New York. In 1986 he began private practice with Portsmouth Orthopedics Associates, Inc., and became the practice Medical Director in 1989. He remains the medical director for the orthopedic practice. He is Board certified in Orthopedic Surgery and is an oral examiner for the American Board of Orthopedic Surgery. He is a Fellow of the American Academy of Orthopedic Surgeons and the American College of Surgeons.

DISCUSSION

The evidence of record establishes that the Claimant was seen in May 1990 for acute right knee swelling following three months of work on his knees. He underwent arthroscopic surgery of the right knee on July 9, 1990, which was performed by Dr. Stiles. On January 24, 1991, Dr. Stiles classified the Claimant with a 15% permanent disability of the right leg and stated that the Claimant should be on permanent work restriction of "no climbing." There is no indication in the record that the Claimant received disability compensation or medical treatment under the Act for this 1990-1991 right knee event.

The Claimant sustained a right knee work-related injury on January 8, 1996. He underwent arthroscopic surgery for the right knee on May 8, 1996. He was paid temporary total disability compensation under the Act for various times from March 5, 1996, through May 26, 1997, and paid permanent partial disability based on a 20% permanent disability to the lower right extremity.

The Claimant sustained a left knee work-related injury on February 12, 2004. He underwent arthroscopic surgery for the left knee on March 3, 2004. By the December 30, 2004, Order of the District Director, the Claimant was determined to have a left knee work-related injury that resulted in payment of temporary total disability compensation from February 19, 2004, through August 16, 2004, and permanent partial disability for 20% loss of use of the left lower extremity.

Claimant now seeks to have his current right knee difficulties classified as being the proximate result of the left knee injury of February 12, 2004, and requests entitlement to medical treatment under the Act for the right knee condition.

Under the "aggravation rule" of the Act, if a second traumatic injury at work accelerates, aggravates, or combines with an employee's pre-existing traumatic-based disability, the employer is liable for the employee's entire resulting disability, not only the disability that would have been due to the second work-related injury alone. If after the second traumatic injury, the condition of the first traumatic-based impairment is at a level that would be expected in the natural progression, or unavoidable consequence, of the initial injury over time, the second traumatic injury may not be considered to have "accelerated, aggravated or combined with" the first impairment. If the ultimate disability is materially and substantially greater than that which would have resulted from the second work-related injury without the pre-existing impairment, the provisions of Section 908(f) may apply to the employer's benefit. *Newport News Shipbuilding and Dry Dock Co., v Fishel,* 694 F.2d 327 (4th Cir., 1982); *Director, OWCP v. Newport News Shipbuilding and Dry Dock Co. (Carmines),* 138 F.3d 134 (4th Cir. 1998); *Admiralty Coatings Corp. v. Emery,* 228 F.3d 513 (4th Cir., 2000); *Newport News Shipbuilding and Dry Dock Co. v. Ward,* 326 F.3d 434 (4th Cir., 2003); *Metropolitan Stevedore Co., v. Crescent Wharf and Warehouse, Co.,* 339 F.3d 1102 (9th Cir., 2003), *cert denied,* 543 US 940 (2004).

Here, the Claimant had a pre-existing right knee work-related medical condition, under the Act, prior to the left knee injury of February 12, 2004. In order for the Claimant to have additional

coverage of the right knee out of the February 12, 2004, work-related injury, the Claimant must establish that the February 12, 2004, left knee injury accelerated, aggravated or combined with the pre-existing right knee impairment. The Claimant submitted a statement from his treating orthopedic surgeon (CX 4) in which Dr. Stiles reported treating the Claimant in 2005 for right knee pain, a torn meniscus and areas of chondromalacia and opined that the Claimant's "injury of 2004 and his subsequent surgery and the time that was spent when he was unable to put weight on the left side has contributed to the (2005) problem in his right knee." Accordingly, the Claimant is entitled to the presumption that he suffered a harm which could have accelerated or aggravated his pre-existing work-related impairment. 33 USC § 920; *Gencarelle v. General Dynamics Corp*., 22 BRBS 170 (1989) *aff'd* 892 F.2d 173 (2d Cir. 1989)

Once entitlement to this presumption is established, the Employer has the burden to demonstrate with substantial countervailing evidence that the post-February 12, 2004, right knee condition was not accelerated, aggravated or combined with the left-knee work-related injury. In establishing the lack of causal nexus, the employer must produce facts, not speculation or mere hypothetical probabilities, to overcome the presumption of compensability. See *Dearing v. Director, OWCP*, 27 BRBS 72 (CRT) (4th Cir. 1993) unpublished; *Dewberry v Southern Stevedoring Corp*., 7 BRBS 322 (1997), *aff'd mem*., 590 F.2d 3312 (4th Cir. 1978); *Bivens v. Newport News Shipbuilding & Dry Dock Co*., 23 BRBS 233 (1990)

The medical records involving the Claimant and Dr. Stiles are contained in the following exhibits: CX 1 (May 12, 2005, to November 17, 2005), EX 6 (April 26, 1990, to July 11, 1996, plus the report of a November 7, 2005, right knee MRI contained in CX 1); EX 8 (February 18, 2004, to November 17, 2005, where five records are duplicative of CX 1); EX 9 (May 3, 1990, to November 17, 2005, where five records are duplicative of CX 1 and an additional five records are duplicative of EX 8); and EX 10 (the left knee operative report of March 3, 2004).

Dr. Stiles' medical entries prior to the February 12, 2004, injury, indicate that the condition of the right knee included good range of motion with obvious arthritic lipping a long the medial and lateral condyle with loose bodies possibly present. He had no instability, real effusion, redness or heat (EX 9, March 26, 2003). On May 8, 1996, the Claimant had his second right knee arthroscopic surgery. Loose bodies were suctioned out in several areas, condylar surfaces, femur and lateral tibial plateau were debrided. No tears were seen during the surgery. (EX 6) Dr. Stiles reported weak quadriceps with moderate crepitation on flexion-extension without effusion during the 1996 post-surgical recovery. On July 11, 1996, Dr. Stiles opined that the Claimant had an "old internal derangement – right knee" and was not totally disabled. On September 15, 1997, Dr. Stiles reported that the May 8, 1996, right knee arthroscopic surgery revealed "rather severe post-traumatic arthritic findings with loss of condyle cartilage in both the medial and lateral compartments and patella femoral compartment. He reported that an August 21, 1997, right knee x-ray "showed narrowing of the medial compartment as well as the patellofemoral compartment." Dr. Stiles opined that the right knee "is going to get worse in the future and he may require further surgery." (EX 9)

After the February 12, 2004 injury, Dr. Stiles reported complaints of pain in both knees in his September 15, 2004, entry. Dr. Stiles reported good range of motion, minimal effusion, some crepitation in McMurray's and no marked instability (EX 9). The same observations were

entered by Dr. Stiles on May 12, 2005 and August 10, 2005. Symptoms were treated with Motrin and exercise (CX 1). On September 15, 2005, Dr. Stiles reported x-rays of the knees showed rather marked traumatic arthritis in both knees with marked lipping on the tibia and femoral condyles and the narrowing of the medial compartment with approximately one centimeter space remaining in the right knee. (CX 1) These are essentially the same findings Dr. Stiles reported during his examinations of the right knee following the May 8, 1996 surgery through the period immediately prior to the February 12, 2004 left knee work-related injury.

On November 1, 2005, the Claimant had a fall and twisting injury involving the right knee (CX 1). A November 7, 2005 MRI of the right knee indicated the anterior cruciate ligament as thin/attenuated most consistent with previous insult and incomplete tear and moderate to advanced degenerative change in the medial joint compartment with thinning of articular cartilage and formation of prominent osteophytes with joint space narrowing. An abnormal signal was consistent with a free-edge tear in the medial meniscus and anterior horn of the lateral meniscus. There was also moderate thinning of the patellar articular cartilage and patellofemoral degenerative change with osteophytes. (CX 3) Dr. Stiles concurred with the MRI assessment of a tear of the medial and lateral meniscus on November 17, 2005 and prescribed exercise, activity and anti-inflammatory medications.

The objective finding and clinical signs of the right knee reported by Dr. Stiles prior to the February 12, 2004, were essentially unchanged through September 15, 2005. It was not until after the November 1, 2005 right knee twisting injury that objective medical imaging revealed a torn medial and lateral meniscus. No physician attributes this torn meniscus finding to the left knee work-related injury. The treating physician, Dr. Stiles, acknowledges the torn meniscus and areas of chondromalacia in his September 2006 letter but goes on to opine that the February 12, 2004, left knee injury, March 3, 2004, left knee arthroscopic surgery, and post-op period spent in no-weight bearing on the left side through approximately April 20, 2004, "has contributed to his problem in his right knee." (CX 4, EX 8 and 9) Dr. Stiles does not explain what "contributed" means or how he came to the opinion that there was a left knee "contribution" to the right knee condition. Dr. Stiles fails to explain how the February 12, 2004, left knee injury and course of treatment may have accelerated the deterioration of the right knee, how the left knee injury and course of treatment aggravated the right knee condition, or how the left knee injury and course of treatment may have combined with the pre-existing right knee condition to cause a greater harm/disability. Accordingly, Dr. Stiles opinion of the left knee injury and course of treatment contributing to the right knee impairment is not entitled to controlling weight.

In contrast to Dr. Stiles, Dr. S.C. Blasdell, examined the Claimant on October 31, 2006, a year after the November 1, 2005 right knee twisting injury and fall. Dr. Blasdell also reviewed the medical records of the treating physician contained in CX 1, EX 6, 8, and EX 9. X-rays of the knees ordered by Dr. Blasdell indicated severe osteoarthritis bilaterally with osteophytes, varus deformities and osteopenia. Examination showed bilateral medial and lateral joint tenderness of the knees. Dr. Blasdell opined that the right knee arthritis and current right knee impairment was unrelated to the February 12, 2004, left knee work injury. (EX 4)

Dr. P.S. Apostoles, submitted a written report of his medical record review of Claimant's medical treatment history of the right and left knees. Dr. Apostoles points out that the Claimant was post-operative arthroscopic surgery times two for the right knee prior to the February 12, 2004, left knee injury. He notes that the Claimant did not complain of increased right knee symptoms until September 15, 2004. He opines that while the right knee torn meniscus may be attributable to the November 1, 2005, acute twisting injury "it is more probable than not the result of the previous right knee surgeries and natural progression of the pre-existing condition in the right knee." Dr. Apostoles states that the left knee injury did not lead to the pathology or disability attributable to the right knee and states that there is sufficient evidence to explain the right knee disability independent of the left knee injury. (EX 5)

The curriculum vitae for Dr. Blasdell and Dr. Apostoles set forth their credentials and experience in orthopedic medicine. Dr. Stiles' curriculum vitae is not in evidence; however, he is an approved orthopedic surgeon under the Act.

The evidence of record as a whole fails to establish a change in the right knee degenerative condition immediately prior to and after the February 12, 2004, left knee surgery, non-weight bearing recovery, and prescribed left knee physical therapy. On July 19, 2004, the Claimant was released for a light duty work position with restrictions. On August 16, 2004, the treating physician removed the work restrictions. It was not until September 15, 2004, that the Claimant complained of pain in both knees, left greater than right, after working on cement. Even then, the treating physician did not begin to treat and follow the right knee complaints until May 12, 2005, over a year after the left knee traumatic injury. The objective imaging of the right knee from September 15, 2005, is similar to the right knee condition prior to the left knee traumatic injury. The demonstrated change in right knee condition which followed the November 1, 2005, right knee twisting injury was by an MRI that disclosed torn medial and lateral meniscus. Dr. Stiles does not attribute the torn meniscus changes to the left knee injury and course of treatment. Dr. Blasdell does not attribute the torn meniscus changes to the left knee injury. Dr. Apostoles acknowledges that the torn meniscus changes may be attributable to the November 1, 2005, twisting right knee injury but was probably attributable to the natural progression of the right knee degenerative process. In view of all the foregoing, this Administrative Law Judge finds that the Claimant has failed to establish, and the Respondent has successfully rebutted, that the left knee injury "accelerated" the right knee deterioration.

The evidence of record as a whole fails to establish an "aggravation" of the pre-existing right knee impairment. Dr. Stiles states there is a "contribution" from the combination of the left knee injury, left knee surgery and period of non-weight bearing prescribed in the course of treatment, but there was no right knee complaints after the February 12, 2004 left knee injury for nearly five months, well past the non-weight bearing left period and return to work. Even then the complaint was of right knee pain consistent in nature to pain complaints made to the treating physician through March 2003. The evidence as a whole is more consistent with the analysis and opinion of Dr. Apostoles that the medical evidence explains the right knee pathology and disability as independent of the left knee injury. Dr. Blasdell's subsequent analysis of the medical records and October 2006 examination of the Claimant led to his medical opinion that the Claimant did not sustain any right knee injury as a result of the February 12, 2004 work-related left knee injury and that the right knee arthritis and impairment is unrelated to the left

knee injury. This is consistent with the earlier analysis of Dr. Apostoles. In view of all the foregoing, this Administrative Law Judge finds that the Claimant has failed to establish, and the Employer has successfully rebutted, that the left knee injury "aggravated" the right knee deterioration.

The evidence indicates that the left knee was treated and stabilized. No medical opinions which are consistent with the evidence indicate that the traumatic injury to the left knee on February 12, 2004, "combined" with the pre-existing right knee medical condition to make the left knee trauma worse than it would have been if the right knee had not had a pre-existing work-related impairment. The treatment records indicate that the left knee injury was appropriately treated and stabilized. Accordingly, this Administrative Law Judge finds that the Claimant has failed to establish, and the Respondent has successfully rebutted, that the left knee traumatic injury "combined" with the pre-existing right knee impairment.

CONCLUSION AND FINDINGS OF FACT

After deliberation on all the evidence of record, including post-hearing briefs of counsel, this Administrative Law Judge finds:

1. On February 12, 2004, the Claimant had a pre-existing impairment to the right knee following a January 8, 1996, work-related traumatic injury and course of treatment to the right knee.

2. On February 12, 2004, the Claimant sustained a work-related traumatic injury to the left knee.

3. The medical condition of the right knee following surgical treatment in May 8, 1996, through the fall of 2005, was of that level expected in the natural progression of the right knee over time.

4. The February 12, 2004, work-related traumatic injury to the left knee did not accelerate, aggravate or combine with the pre-existing traumatic-based right knee disability.

5. The Claimant did not sustain a right knee injury as the proximate result of the covered work-related injury to the left knee on February 12, 2004.

6. The Claimant is not entitled to additional right knee medical treatment under the Act based upon the February 12, 2004, work-related traumatic injury to the left knee.

ORDER

It is hereby ORDERED that the Claimant's request for additional right knee benefits, under the Act, based on the covered work-related traumatic injury to the left knee on February 12, 2004, **is DENIED**.

A

ALAN L. BERGSTROM
Administrative Law Judge

ALB/jcb
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